Loudoun County
Department of Parks, Recreation and Community Services

LONG TERM MEDICATION AUTHORIZATION

Childcare Program Site: _____

I certify that, in my opinion, it is medically necessary that the medication described below be administered to _____during center hours and that this medication may be administered by center staff.

Prescription:

Medication: _____

Dosage and Time: _____

Duration: _____

Date of Prescription: _____

_____
Signature of Physician

_____
Date

****

I _____, the parent or guardian of

_____, request that center staff administer the medication prescribed above to my child during center hours. I understand that the person who will administer the medication may be inexperienced. I also agree to furnish said medication in the container supplied by the drug store with the label intact.

_____
Signature of Parent or Guardian

_____
Date

MEDICATION LOG

Record of receiving, dispensing, and returning medication.

Date	Medication Name	Date RX Received	Time RX Dispensed	Amount RX Dispensed	Any Adverse Reaction?	Any Medication Errors?	Date RX Returned	Staff Initial